

Rome V in paediatrics

What dietitians need to know

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DECLARATIONS

I have provided consultancy for, and worked with:

Abbott

Nutricia

Symprove

Mead Johnson

TODAY

Not every disorder in Rome V. The changes that matter for dietitians.

Rome V came out in May. It has moved on from what most of us learned.

FOLLOW ONE CHILD WITH ME

Meet Maya

3 months

3 years

8 years

10 years

A composite child, built from patterns seen in clinic. Not a real patient.

Rome V: the paediatric map

Disorders of gut–brain interaction in children and adolescents

Upper GI

Oesophageal

Reflux hypersensitivity

Reflux-negative oesophageal pain disorder

Aerophagia syndrome

Supragastric belching syndrome

Functional feeding disorders

Hypersensitive dysphagia

Anticipatory restrictive feeding

Hunger dysregulation

Medically triggered functional feeding disorder

Gastroduodenal

Rumination syndrome

Cyclic vomiting syndrome

Chronic nausea syndrome
was functional nausea

Functional dyspepsia

Lower GI

Abdominal pain

Irritable bowel syndrome

Abdominal pain syndrome NOS
was FAP-NOS

Abdominal migraine

Biliary pain syndrome

Centrally mediated abdominal pain syndrome

Defecation

Functional constipation

Nonretentive faecal incontinence
was functional NRFI

Infant dyschezia

Functional diarrhoea

Proctalgia fugax

Discomfort

Functional abdominal bloating

Infant distress syndrome
was infant colic

THE HEADLINE CHANGE

Organised by part of the gut, not by age

Rome IV

Neonates and toddlers in one chapter. Children and adolescents in another.

Rome V^{1, 2}

Upper GI and lower GI. Pain, defecation and discomfort disorders. One set of criteria across ages for most disorders.

But age still matters inside the criteria: IBS from 6 years. Infant distress syndrome onset under 5 months. Infant dyschezia under 9 months.

MAYA · 3 MONTHS

"She screams every evening from six o'clock. Nothing we do settles her. Is it the milk?"

Feeding well

Growing along her
centile

Normal stools

Possets a little

POLL · TYPE A, B OR C IN THE CHAT

Is this cow's milk allergy?

A Yes. Start a dairy-free trial.

B Not enough information yet.

C It's colic. Reassure.

Red flags (proposed)

- Extreme or high-pitched cry
- No day-night pattern
- Starts after 4 months of age
- Frequent regurgitation, vomiting or diarrhoea
- Weight loss or faltering growth
- Maternal drug use; abnormal examination

Rome V also advises a urine check in afebrile infants with excessive crying in the first few months.

RENAMED

Infant colic Infant distress syndrome

"Colic" implies pain from the colon. That has never been shown. The new name describes what we actually see: a distressed infant.

The clinical criteria

H3b. Diagnostic Criteria for Infant Distress Syndrome

For clinical purposes, must include *all* the following:

1. An infant who is younger than 5 months of age when the symptoms start
2. Recurrent and prolonged periods of infant crying and fussing reported by caregivers that occur without obvious cause and cannot be prevented or resolved by caregivers
3. After appropriate evaluation, the symptoms cannot be fully explained by another medical condition

What's changed

- Symptoms no longer have to stop by 5 months
- “No faltering growth, fever or illness” replaced by “after appropriate evaluation”
- The 3-hour threshold called arbitrary: severe impact on a caregiver now counts

Allergy or infant distress?

Crying alone is not enough¹

- “There is insufficient data to support infant colic occurring as a single manifestation of CMA.”
- “In infants who present with crying and irritability, there is insufficient data to recommend a time-limited CM elimination diet for 2–4 weeks followed by an OFC.”

Signs that suggest CMPA²

- Usually several symptoms, 2 to 72 hours after milk
- Vomiting, loose or frequent stools, soft stools with straining, blood or mucus
- Eczema or rashes; food refusal
- Resistance to usual treatment; atopic family history

Suspect CMPA only with additional signs on an allergy-focused history. Then trial for 2 to 4 weeks and reintroduce to confirm¹.

What Rome V says helps

The cornerstone¹

Validate the baby's distress and the parents' burden. Reassure. Explain it is self-limiting.

Probiotics^{1,2}

L. reuteri DSM 17938 is the most studied. Effective in young breastfed infants with colic; unclear in formula-fed.

Diet^{1,3}

Rome V: removing cow's milk "may be beneficial", but the evidence is scarce with significant risk of bias. ESPGHAN: not for crying alone. Only if there are other signs of CMPA.

Very weak evidence: lactase, simethicone, herbs, PPIs. Ask about parental anxiety and low mood.

MAYA · 3 YEARS

"Four or five runny poos a day. She doesn't seem bothered, but we are."

No tummy pain

Growing well

2 to 3 cups of juice a
day

For 3 months

POLL · TYPE A, B, C OR D IN THE CHAT

What's Maya's working diagnosis?

A Toddler diarrhoea

B Functional diarrhoea

C IBS with diarrhoea

D Cow's milk allergy

FUNCTIONAL DIARRHOEA

Not just a toddler problem any more

Rome V extends functional diarrhoea from 6 months all the way to 18 years.

Stool frequency now depends on age

H2e. Diagnostic Criteria^a for Functional Diarrhea

Must include *all* the following:

1. Passage of an average of 4 or more painless bowel movements daily in children younger than 4 years or more than 2 bowel movements daily in children 4 years or older, with at least 25% of stools being unformed^b
2. Onset between 6 months and 18 years of age
3. Does not meet criteria for functional constipation, diarrhea-predominant irritable bowel syndrome, and nonretentive fecal incontinence
4. After an appropriate evaluation, the diarrhea cannot be fully explained by another medical condition

^aCriteria fulfilled for at least 2 months before diagnosis.

^bBristol Stool Form Scale or Brussels Infants and Toddlers Stool Scale type 6 or 7 in infants/children with diapers.

Under 4 years

4 or more

painless stools a day, on average

4 years and over

More than 2

painless stools a day, on average

Maya, 3 years: 4 to 5 loose stools a day, so she meets the under-4 threshold

Pain decides

Functional diarrhoea

Loose stools without significant pain. Any age from 6 months to 18 years.

IBS with diarrhoea

Pain is the predominant symptom. Only from 6 years.

Symptoms overlap. Ask which one bothers the child most.

Look at what she's eating and drinking first

- Dietary evaluation is recommended, especially juice and fructose in young children
- Most toddlers and preschoolers need no medical treatment
- Rome V: low FODMAP may be trialled in older children (expert opinion). I use a modified approach.
- Complete a diet history and review fibre and fluid intake

Check the alarm features first: weight loss, faltering growth, nocturnal or high-volume diarrhoea, blood in stools, raised inflammatory markers.

MAYA · 8 YEARS

"My tummy hurts most days. It's better after I've been to the toilet."

Hard stools, Bristol 1 to 2

Opens bowels twice a week

The pain bothers her most

For 4 months

POLL · TYPE A OR B IN THE CHAT

Constipation or IBS?

A Functional constipation

B IBS with constipation

The Rome V criteria

H1a. Diagnostic Criteria^a for Irritable Bowel Syndrome

Must include *all* the following:

1. Intermittent abdominal pain on average of at least 4 days per month associated with 1 or more of the following:
 - a. Related to defecation (ie, worsening or amelioration of)
 - b. A change in frequency of stool
 - c. A change in form (appearance) of stool
2. Abdominal pain is the predominant symptom^b
3. After appropriate evaluation, the symptoms cannot be fully explained by other medical conditions

^aCriteria fulfilled for at least 2 months before diagnosis.

^bPain should not occur solely during menses.

- Pain is the predominant symptom
- From 6 years of age
- Not pain only during menses
- Subtypes by the share of abnormal stools on the Bristol scale, as in adults

"Treat the constipation first" has gone

Rome IV

Treat the constipation. If the pain resolves, it was constipation. If it persists, consider IBS.

Rome V

Pain as the predominant symptom, relieved by defecation, means IBS (when full IBS criteria are met). Same approach as adult criteria.

Why: the type, dose and length of constipation treatment, and how much pain had to improve, were not well specified.

Two changes to know

6+

Minimum age 6 years

No studies describe IBS in younger children.

Menses

New exclusion

Pain only during periods is likely dysmenorrhoea, not IBS.

In IBS-D: screen for coeliac disease, and consider carbohydrate and bile acid malabsorption.

Clearer wording for all ages

H2a. Diagnostic Criteria^a for Functional Constipation

- Must include at least 2 of the following occurring in the past month:
 - On average, 2 or fewer defecations per week
 - On average, at least 1 episode of fecal incontinence per week^b
 - History of retentive posturing, straining, or inappropriate stool retention
 - History of painful or hard^c bowel movements
 - Presence of a large fecal mass in the rectum
 - History of large diameter stools
 - After appropriate evaluation, the symptoms cannot be fully explained by another medical condition
 - Does not fulfill criteria for irritable bowel syndrome

^aCriteria fulfilled for at least 1 month before diagnosis.
^bThis criterion only applies to children who have been toilet-trained.
^cBristol Stool Form Scale type 1 or 2, or Brussels Infants and Toddlers Stool Scale type 1, 2, or 3 for infants.

Rome IV	Rome V
At least once per week	Occurring in the past month
Developmental age at least 4 years	Removed; incontinence criterion only if toilet-trained
Excessive volitional stool retention	Inappropriate stool retention; "straining" added
Painful or hard bowel movements	Hard defined as Bristol 1 to 2, or Brussels 1 to 3
Large stools that may obstruct the toilet	History of large-diameter stools

Must not meet IBS criteria. Normal fibre and fluid intake recommended.

Functional abdominal bloating

H3a. Diagnostic Criteria^a for Functional Abdominal Bloating

Must include *all* the following:

1. Intermittent bloating and/or distention occurring on average at least 4 days per month; abdominal bloating and/or distention predominate over other symptoms^b
2. There are insufficient criteria for a diagnosis of irritable bowel syndrome, functional constipation, functional diarrhea, aerophagia, or postprandial distress syndrome
3. After appropriate evaluation, the bloating cannot be fully explained by another medical condition

^aCriteria fulfilled at least 2 months before diagnosis.

^bMild pain related to bloating may be present as well as minor bowel movement abnormalities.

Why it matters to us

- Only when bloating predominates and other criteria are not met
- Fermentable carbohydrates, fatty meals and stool retention can all drive it
- Dietary history is part of the evaluation
- Paediatric data are scarce

Over 90% of children name a trigger food

Suspected trigger	What Rome V says
Lactose	Most challenge RCTs do not support it as the trigger
Gluten	Data do not support gluten sensitivity as a significant factor
Fructose	One RCT: more pain improvement with 2 weeks' restriction
FODMAPs	May worsen symptoms in a subset of children

If it's used, it needs a paediatric dietitian

1. Restrict

No more than 4 to 6 weeks

2. Reintroduce

Find the real triggers

3. Personalise

Liberalise where possible

Rome V strongly recommends a dietitian in any restriction diet, because of the risk of disordered eating and ARFID¹.

ESPGHAN/NASPGHAN 2025 did not suggest restrictive diets, including low FODMAP, for paediatric IBS².



Before we cut out FODMAPs...

MAYA · 10 YEARS

"She's scared to eat now. She thinks food will make the pain come back."

Dairy-free since infancy

Gluten-free after advice online

Low FODMAP, never reintroduced

Fearful when asked to try new foods

Reports nausea

Only eats specific foods in her school lunchbox

Low iron status

MAYA · 10 YEARS

Maya has anticipatory restrictive feeding.

Let me tell you what that is...

Time to eliminate ARFID?

First, one umbrella definition (G2). Then four subtypes.

ALTERED FEEDING PATTERNS THAT

- Interfere with functioning
- Occur at least 3 times a week
- Are not explained by a medical or skill-based diagnosis that has been effectively evaluated and managed

For at least 1 month

PLUS AT LEAST 1 OF

1 Nutritional compromise (micro or macronutrient)

2 Supplemental enteral or parenteral nutrition

3 Active or passive avoidance behaviours

4 Restricted or selective diet used to treat symptoms

5 Lack of expected self-feeding

6 Excessive feeding strategies: chewing, washing down, pacing

Time to eliminate ARFID?

One umbrella definition (G2), then four subtypes:

Anticipatory restrictive feeding

Fear of pain, nausea, vomiting or choking with eating

Medically triggered functional feeding disorder

Skills stall or regress after an illness, and stay stuck once it is treated

Hunger dysregulation disorders

Reduced or excessive hunger drive

Hypersensitive dysphagia

Food feels stuck, with normal swallow tests

“We propose that the term ARFID should be eliminated and replaced by more precise terms.” DSM-5 still uses it.

Hypersensitive dysphagia

G2A

A feeding disorder characterised by perception of liquids and/or solid foods passing abnormally through the oropharynx or oesophagus that is associated with *all* of the following characteristics:

- 1 No evidence of pharyngeal or oesophageal mucosal or structural abnormalities
- 2 Absence of major oesophageal motor disorders
- 3 No evidence of bolus transit abnormalities

Anticipatory restrictive feeding

G2B

A functional feeding disorder driven by the anticipation of aversive experiences while eating and is associated with 1 or more of the following:

- 1 Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
- 2 Significant nutritional deficiency
- 3 Dependence on enteral feeding or oral nutritional supplements
- 4 Marked interference with other psychosocial functioning

Over 80% have underlying GI symptoms. This is Maya.

Hunger dysregulation disorders

G2C

A feeding disorder that is characterised by either:

- 1 G2c.i.** Reduced hunger drive: The patient will not voluntarily eat or drink calorically appropriate foods after periods of age-appropriate fasting AND the patient requires prompting and/or scheduling of meals in order to ensure adequate intake.
- 2 G2c.ii.** Excessive hunger drive: The patient has excessive hunger manifested by inability to stop eating even after finishing a meal and excessive eating between meals even after completing a full meal.

Medically triggered functional feeding disorder

G2D

A feeding disorder that:

- 1 Developed in the context of a medical condition but the feeding dysfunction persisted after the medical disorder has resolved or is adequately treated and cannot be attributed to the underlying medical condition
- 2 Manifests as a regression or lack of progression of feeding patterns or skills that previously achieved and cannot be attributed to the medical condition

Questions to ask every child

Table 1.Suggested Questions to Consider for Functional Feeding Diagnoses	
Disorder	Key questions
General	How long does a meal take to complete? Do you need your food cut up in small pieces? Do you chew your food more than others? How much liquid do you drink with each meal? Does feeding happen overnight? What happens if meals are off schedule? What are preferred foods? What are avoided foods? Has there been weight loss? Gain? Are meals stressful for you? For your family? Are there any allergies? Are there any cultural requirements for meals? How do you eat at home compared to school? Can you go out to eat as a family? Do you need to bring food with you when you leave the house and if so, why? Do you have issues wearing clothes with tags or walking on sand or grass barefoot? Are you bothered by loud noises?

Hypersensitive dysphagia and anticipatory restrictive feeding

Table 1. Suggested Questions to Consider for Functional Feeding Diagnoses

Disorder	Key questions
HD	Do you feel that liquids, solids or both get stuck? Are there particular foods that get stuck? What makes the stuck feeling go away? How much liquid do you need to drink at a meal? How much chewing is required during a meal?
ARF	Do you experience worry about eating? What symptoms have been associated with a meal? After a meal? Are there foods that you typically worry about eating and what happens if you try to eat them? Are you able to go out to eat with friends?

Hunger dysregulation disorders and medically triggered functional feeding disorder

Table 1. Suggested Questions to Consider for Functional Feeding Diagnoses	
Disorder	Key questions
Hunger dysregulation disorder	How long can you go without eating? What happens if you cannot eat due to a change in schedule, fasting for medical procedures? Do you need to lock up food between meals? Do you graze on food throughout the day?
Medically triggered functional feeding disorder	Can you pinpoint when the feeding trouble started? Are you able to eat age-appropriate food consistencies (liquids, semisolids, solids) before the medical condition started? Have you had any infections? Do you take any medications? Have you received any new medical diagnoses? When was the last assessment of medical conditions? What testing have you recently had done?

When the gut settles, eating often follows

- Maximise symptom control to improve behavioural outcomes
- Outpatient nutritional management is feasible and preferred; most do not need tubes
- Low FODMAP, gluten-free and dairy-free diets are not usually recommended: they can increase meal-related anxiety and trigger or worsen a feeding disorder

WHERE THE FEAR OFTEN STARTS

“One common cause for feeding-related anxiety is the initial restriction of food in an effort to improve GI symptoms. This could be driven by well-intentioned self or family observation, medical recommendations, or online social media.”

Maya: dairy-free, gluten-free, low FODMAP. All three.

OVER TO YOU · IN THE CHAT

Have you seen a child start eating again once their tummy settled?

Emma takes us deeper into selective eating straight after this talk.

Centrally mediated abdominal pain syndrome

H1e. Diagnostic Criteria^a for Centrally Mediated Abdominal Pain Syndrome^b

Must include *all* the following:

1. Continuous abdominal pain
2. Pain limits daily functioning^c
3. After appropriate evaluation, the symptoms cannot be fully explained by other medical conditions

^aCriteria fulfilled for at least 2 months before diagnosis.

^bCentrally mediated abdominal pain syndrome is typically associated with psychosocial comorbidity, but there is no specific profile that can be used for diagnosis.

^cDaily activities include impairment in school, social/leisure, family life, and sports.

Management

- Continuous pain, unlike the intermittent pain of APS-NOS
- Multidisciplinary care with family and school
- Brain-gut therapies strongly recommended¹: CBT, hypnosis, psychopharmacology, PENFS
- Paediatric data are limited
- Some IBS/FAP-NOS guideline² treatments “may apply”¹

"Nothing makes the pain go away"

Chronic constipation; one disimpaction, traumatic

Refusing laxatives

Months off school with pain

Pain described as continuous

Coeliac screen inconclusive

Feels better on reduced gluten

Dietetic win: diet and fluids took bowel opening from 1 to 2 times a week to daily. The pain stayed.

SUSPECTED CAPS

Not yet.

Ongoing faecal retention¹

Disimpaction still under discussion. Pain is common in defecation disorders and often improves once constipation is treated.

Coeliac not excluded²

A repeat screen needs adequate gluten in the diet. Reducing gluten first can muddy the result.

The new label is tempting. The basics come first.

1. Di Lorenzo et al. Gastroenterology 2026 2. NICE NG20, Coeliac disease, 2015

Other updates to know about

Disorder	What changed
Rumination syndrome ¹	One set of criteria for all ages; must fail reflux treatment first
Chronic nausea syndrome ¹	New name for functional nausea
Functional dyspepsia ¹	Postprandial distress now 3 days a week, up from 1
APS-NOS ²	New name for FAP-NOS; intermittent pain, not only with meals, menses or bowel movements
New diagnoses ^{1,2}	Biliary pain syndrome and proctalgia fugax ² ; oesophageal disorders ¹

1. Rosen et al. Gastroenterology 2026 2. Di Lorenzo et al. Gastroenterology 2026

TAKE THIS ONE WITH YOU

Before any restriction

- 1. Has the diagnosis been checked?**¹ Red flags, coeliac, faecal retention.
- 2. What is the child eating now?** Juice¹, takeaways, regular meals.
- 3. Have the basics been tried?** Normal fibre and fluid¹, bowel routine.
- 4. What will this restriction cost?**^{1,2} Nutrition, social life, fear of food.
- 5. Who reintroduces, and when?**¹ Time-limited, with a paediatric dietitian.

Based on 1. Di Lorenzo et al. Gastroenterology 2026 2. Rosen et al. Gastroenterology 2026

A diagnosis is where the
assessment starts, not where it
ends.



Thank you. Questions?

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7. National Institute for Health and Care Excellence. Coeliac disease: recognition, assessment and management. NICE guideline NG20. London: NICE; 2015.